MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8485 Item 2 Film G291 7/24/61 iwk

CERTIFICATE OF DEATH

08479

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Boonsboro/ Hagerstown,
d. STREET ADDRESS: 248 S. Prospect St. / Fahrney-Keedy Home //
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BLANCHE	SEIBERT	ANKENEY	July	15	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		May 25 1874	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Md. Clear Spring Wash Co	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David Ankeney	Sallie Seibert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	--	None	Bayard W. Goslin 31 Red Oak Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hagerstown Md. Cerebral Thrombosis & Rt Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 11 days -
DUE TO (b): generalized & cerebral atherosclerosis — Unknown
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease - — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-8, 19 45 to 7-15, 19 61, that (I) (we) last saw the deceased alive on 7-15-61 19, and that death occured at 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
John H Hornbaker M.D.				7-17-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
John H. Hornbaker, M.D.	154 West Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	7/19/61	St Pauls Cemetery	near Clear Spring Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	JUL 19 '61	Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8485

CERTIFICATE OF DEATH

08480

1 (M)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5½ Hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R # 4
d. STREET ADDRESS: Resh Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle OMER — Last ARNSPARGER Sr

4. DATE OF DEATH: Month July — Day 18 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Feby 14 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner- operator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Thurmont Fred. Co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Arnsparger

14. MOTHER'S MAIDEN NAME: Elizabeth Eby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs Anna W Arnsparger Hagerstown R # 4

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Resh Road — Acute pulmonary edema and — INTERVAL BETWEEN ONSET AND DEATH: 4 days
260 X
DUE TO (b): Cardiac Decompensation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes Mellitus & Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign prostate hypertrophy -

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 1, 1961, to July 18, 1961, that (I) (~~we~~) last saw the deceased alive on July 18 1961, and that death occured at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 7/19/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D.

22d. ADDRESS: 217 West Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/21/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Maryland

25a. REC'D BY REGISTRAR — DATE: JUL 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8487 — 08481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 7 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 219 ROBIN WOOD DRIVE

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 219 ROBINWOOD DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: GLADYS — Middle: LILLIAN — Last: BAIR

4. **DATE OF DEATH**: Month: JULY — Day: 13 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 19 1898

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MAPLEVILLE WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM HOFFMAN

14. MOTHER'S MAIDEN NAME: LOTTIE SINNISEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 200-01-1789

17. INFORMANT: MRS. J.E. CUNNINGHAM — Address: 219 ROBINWOOD DRIVE HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension Cardiovascular disease — 10 years +

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 2, 1961 to July 13, 1961, that (I) (we) last saw the deceased alive on July 13 1961, and that death occured at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L L Packer Jr M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/14/61

22c. PHYSICIAN'S NAME (Type): L. L. Packer Jr

22d. ADDRESS: Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY 15 1961

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN WASH. CO. MD

24 FUNERAL DIRECTOR'S SIGNATURE: Wm H. Bast — ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE JUL 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8488 Item23d, Film G292 8/7/61 iwk 08482

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA - RURAL
c. LENGTH OF STAY IN 1b: 65 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO MD. R.1

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA - RURAL
d. STREET ADDRESS: BOONSBORO MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle S. Last BAKER

4. DATE OF DEATH: Month JULY Day 29 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 25 1866
9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR: Months 9 Days 4 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): WASH. Co. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JACOB STINE
14. MOTHER'S MAIDEN NAME: NANCY GREENAWALT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. GERALD BOWERS Address: BOONSBORO MD. R.1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart D
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: June 14-61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 28, 19 59, to July 29, 19 61, that (I) (we) last saw the deceased alive on July 29, 19 61, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Sidney Rovenstein M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-31-61
22c. PHYSICIAN'S NAME (Type): SIDNEY ROVENSTEIN
22d. ADDRESS: TURKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 1, 1961
23c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY
23d. LOCATION (City, town or county) (State): Nr. Tilghmanton, Wash. Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE AUG 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8489 — 08483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 921 D Main Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Harold — Last: Baker

4. **DATE OF DEATH**: Month: July — Day: 8 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 16 / Min. 16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Warren D. Baker

14. MOTHER'S MAIDEN NAME: Esther U. Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Warren D. Baker 921D Main Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO (b): Prem atarity — few hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-7, 1961, to 7-8, 1961, that (I) ~~(saw)~~ last saw the deceased alive on 7-8-1961, and that death occured at 2:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: E. Margaret Sullivan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-10-61

22c. PHYSICIAN'S NAME (Type): E. MARGARET SULLIVAN

22d. ADDRESS: 314 N. POTOMAC Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 10, 1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2181318XV Wm. A. Horst

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3450

CERTIFICATE OF DEATH

08484

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 27 Cleveland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cora — Middle: — Last: Barnhart

4. DATE OF DEATH: Month: July — Day: 5 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARR.ED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 3, 1881

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Franklin Co., Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David B. Wishard

14. MOTHER'S MAIDEN NAME: Clara Koons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: - - -

17. INFORMANT: Mr. Ralph Barnhart — Address: Waynesboro, Penna.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 450.0 — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

(a) General arteriosclerosis with
(b) arteriosclerotic heart disease
(c)

INTERVAL BETWEEN ONSET AND DEATH: 5 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility due to above etiology

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June 29, 1961 to July 5, 1961, that (I) (~~we~~) last saw the deceased alive on July 5, 19 61, and that death occured at 11:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D. — ATTENDING PHYS. ☒ — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 7/7/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D.

22d. ADDRESS: 217 West Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/8/61

23c. NAME OF CEMETERY OR CREMATORY: Green Hill — ADDRESS: Waynesboro, Penna.

23d. LOCATION (City, town or county) (State): Waynesboro, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: Walter B. Grove — Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE: JUL 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kerr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8491

CERTIFICATE OF DEATH

C8485

1

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 407 Sherwood Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna — b. COUNTY: Northumberland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patsontown R.F.D.
d. STREET ADDRESS: ---- 21X-1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CARRIE	BENNETT	BELFORD	July	20	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	XX	Sept 16 1883	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City or County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Jefferson Co Summit Point Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Bennett	Ella Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	Mrs Eva Schlotterbeck	407 Sherwood Dr Hagerstown Md. Jefferson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: 2 years.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-26-59, 19..., to 7-20-61, 19..., that (I) (we) last saw the deceased alive on July 20, 1961, and that death occured at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22b. DATE SIGNED
R.A.Bell					7-21-61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
R.A.Bell, M.D.	Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	7/23/61	Rest Haven Cemetery	Hagerstown Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	JUL 24 '61	Arthur L. Kruns

PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8492 — 09486

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 18 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1113 Fairview Rd.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 213 West 29th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: WILMER — Last: BOCK

4. DATE OF DEATH: Month: July — Day: 23 — Year: 1961

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 25 1901

9. AGE (In years, last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Waynesboro Franklin Co Pa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry J. Bock

14. MOTHER'S MAIDEN NAME: Mary Rummell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO: 150-10-3611

17. INFORMANT — Address: Mrs Geneva W. Bock 213 W. 29th St Baltimore 11 Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Immed — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 22, 1961, to July 23, 1961, that (I) (~~we~~) last saw the deceased alive on July 22, 1961, and that death occured at 6:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/24/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D.

22d. ADDRESS: 217 West Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/26/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman Hagerstown Md.

ADDRESS

25a. REC'D BY REGISTRAR — DATE: JUL 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8493 — 08487

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maugansville
d. STREET ADDRESS: Reid Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle EDMONDS Last BOWER

4. DATE OF DEATH: Month July Day 19 Year 1961

5. SEX: FeMale

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feby 7 1877

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Frederick Frederick Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eyster Edmonds

14. MOTHER'S MAIDEN NAME: Ida Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): ---

17. INFORMANT: Mrs Hazel Spielman 1010 Hamilton Blvd Hagerstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension Cardio Vascular Dis — 10 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-6-61, 19 to 7-12, 19 61, that (I) (we) last saw the deceased alive on 7-12-61 19, and that death occured 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. E. Dutz M.D.

ATTENDING PHYS. 4 MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A E Dutz

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 22 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

23d. LOCATION (City, town or county) (State): Frederick Frederick Co Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8494

CERTIFICATE OF DEATH

C8488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
   c. LENGTH OF STAY IN 1b: 3 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. Co. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEAVER CREEK - RURAL
   d. STREET ADDRESS: HAGERSTOWN MD. R.1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ROY — Middle: GEORGE — Last: BRANDENBURG

4. **DATE OF DEATH**: Month: JULY — Day: 27 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB 13 - 1880

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months: 5 — Days: 14 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY: NORTH AMERICAN CEMENT Co.

11. BIRTHPLACE (County & State, or foreign country): WOLFSVILLE FRED. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LEVI H. BRANDENBURG

14. MOTHER'S MAIDEN NAME: LOUISE GROSSNICKLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No.

16. SOCIAL SECURITY NO.: 213-10-6919

17. INFORMANT: MRS. LELA BRANDENBURG — Address: HAGERSTOWN MD R1

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic Heart Disease — 4 years

DUE TO (c): Hypertensive vascular Disease — 1½ yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-1-57 19 57 to Jul 27, 1961, that (I) (we) last saw the deceased alive on July 27 1961, and that death occured at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/29/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 30 1961

23c. NAME OF CEMETERY OR CREMATORY: Beaver Creek Cemetery

23d. LOCATION (City, town or county) (State): Beaver Creek Wash. Co. MD

24 FUNERAL DIRECTOR'S SIGNATURE: John W. Bast

ADDRESS: Boonsboro MD.

25a. REC'D BY REGISTRAR DATE: JUL 31 '61

25b. REGISTRAR'S SIGNATURE: Evelyn S. Rinehart

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8495

CERTIFICATE OF DEATH

93489

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown RFD 2

c. LENGTH OF STAY IN 1b: 3 ½ yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Convalescent Home Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport

d. STREET ADDRESS: 1 Conococheague Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emery — Middle: Grafton — Last: Brown

4. DATE OF DEATH: Month: July — Day: 2 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 10 1888

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: 11 — Days: 21 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Coal Yard

11. BIRTHPLACE (State or foreign country): Williamsport Md. dist. U.S.A

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Brown

14. MOTHER'S MAIDEN NAME: Susan Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes — World War I

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mrs. Annie Kreps — Address: Conococheague St. Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Fe. Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7/2/61

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/2/61 19___ to 7/2/61 19___, that (I) (we) last saw the deceased alive on 7/2/61 19___ and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. F. Young M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/4/61

22c. PHYSICIAN'S NAME (Type): L. F. Young

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 5-61

23c. NAME OF CEMETERY OR CREMATORY: Otterbine Cemetery

23d. LOCATION (City, town, or county) (State): Near Williamsport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leigh — **ADDRESS**: Williamsport, Md

25a. REC'D BY REGISTRAR DATE JUL 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8495

CERTIFICATE OF DEATH

08490

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): State Line
d. STREET ADDRESS: State Line
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clara — Middle: D. — Last: Byers

4. DATE OF DEATH: Month: July — Day: 16 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 1 1905
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: House Keeping
11. BIRTHPLACE (State or foreign country): Franklin Co
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Strine
14. MOTHER'S MAIDEN NAME: Ada Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Wm J. Franklin Byers — Address: State Line Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO (b): Mental Disorders of Involutional — 6 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Coronary Occlusion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 26, 19 61, to July 16, 19 61, that (I) (we) last saw the deceased alive on July 16 19 61, and that death occurred at 7:25 P.M., from the causes and on the date stated above

22a. SIGNATURE: Paul F. Webster M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 18 July 61
22c. PHYSICIAN'S NAME (Type): Paul F. Webster, M.D.
22d. ADDRESS: 27 S. Carlisle St., Greencastle, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/19/1961
23c. NAME OF CEMETERY OR CREMATORY: Beautiful Cemetery
23d. LOCATION (City, town, or county) (State): Washington Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman
ADDRESS: Greencastle, Pa.
25a. REC'D BY REGISTRAR: DATE JUL 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8497 — 08491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1½ wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jackson Convalscent Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 135 North Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HENRY Middle ARLINGTON Last COCHRANE

4. DATE OF DEATH: Month July Day 19 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12,1877

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Platform Foreman (Retired) R.E.A.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hagerstown Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: David Cochrane

14. MOTHER'S MAIDEN NAME: Catherine H. Gantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: 714-05-6869

17. INFORMANT: Mrs. Anna U. Cochrane

Address: 135 N. Locust St Hagerstown Wash. Co. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis
DUE TO (b): Carpet Worker Lung
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) 6 days (b) 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

■. **I certify** that (I) (this hospital) attended the deceased from 6-17-61, 19..., to 7-19, 1961, that (I) (we) last saw the deceased alive on 7-18 1961, and that death occured at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE: A. E. Ditto Jr. M D

22b. DATE SIGNED:

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): A E W Ditto Jr

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/21/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash. Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE JUL 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8493

CERTIFICATE OF DEATH

08492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 45 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 106 E. Salisbury Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport
d. STREET ADDRESS: 106 E. Salisbury St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: Gruber; Last: Conley

4. DATE OF DEATH: Month: July; Day: 17; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9 1879

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months: 9; Days: 7. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Pinesburg Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel Gruber

14. MOTHER'S MAIDEN NAME: Catherine Brubaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Virginia Bowser, 15 N. Conococheague Address: Williamsport Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4201
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) Acute myocardial infarction due to

INTERVAL BETWEEN ONSET AND DEATH: immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/17/61, 19 ..., to 7/17/61, 19 ..., that (I) (we) last saw the deceased alive on 7/17/61, 19 ..., and that death occured at 3:37 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph L. Young M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/18/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 20 61

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: JUL 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8495 — 98493

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 755 S. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Manie — Middle: Viola — Last: Cross

4. DATE OF DEATH: Month: July — Day: 11, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1895

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Funkstown, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles House

14. MOTHER'S MAIDEN NAME: Susan Bagent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-09-6564

17. INFORMANT — Address: James M. Cross 539 N. Locust St. Hagerstown, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 MONTHS

DUE TO (b): CARCINOMA OF THE PANCREAS — 10 MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from April 12, 1961 to July 11, 1961, that (I) (~~two~~) last saw the deceased alive on July 11, 1961, and that death occured at 2:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Antonio A. Pallagrosi M.D.

22b. DATE SIGNED: July 11, 1961

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): ANTONIO A. PALLAGROSI

22d. ADDRESS: Western Md. State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: July 13, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery — 23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. G. Hook — ADDRESS: Rest Haven Funeral Chapel Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 12 '61 — 25b. REGISTRAR'S SIGNATURE: Clifton L. Kinna

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2509 08494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; c. LENGTH OF STAY IN 1b: 18 years; d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 702 Guilford Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland; b. COUNTY: Washington; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; d. STREET ADDRESS: 702 Guilford Ave; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Bertram; Last: Davis

4. DATE OF DEATH: Month: July; Day: 12; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 28, 1904

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months: ; Days: — **IF UNDER 24 HRS**: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. of Car Equipment

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Alfred Davis

14. MOTHER'S MAIDEN NAME: Elma Van Buskirk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 705-10-6426

17. INFORMANT — Address: Mrs. Sarah Russell Davis Hag. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO (b): Coronary occlusion — 1c

DUE TO (c): Arteriosclerotic Heart Disease — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous myocardial infarction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 30 July, 1957 to ____ date ____, 19____, that (I) (we) last saw the deceased alive on 16 Jan 1961, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard T. Binford M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, M. D.

22d. ADDRESS: 1135 POTOMAC AVENUE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park

23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 '61

25b. REGISTRAR'S SIGNATURE: Curtis L. Kraus

VR A1S (4) ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8501 — 68495

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport R # 1
c. LENGTH OF STAY IN 1b: 72 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dellinger Road

2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport R # 1
d. STREET ADDRESS: Dellinger Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: ROMAN — Last: DELLINGER

4. DATE OF DEATH: Month, Day, Year: July 30 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec 26 1888

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Active

11. BIRTHPLACE (County & State or foreign country): Williamsport Wash Co Md. USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William H. Dellinger

14. MOTHER'S MAIDEN NAME: Mary Slifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): Yes W.W.I

16. SOCIAL SECURITY NO.: 215-36-3635

17. INFORMANT: Mrs Ruth S. Dellinger — Address: Williamsport Md. R # 1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1-61, to 7-30-61, that (I) (we) last saw the deceased alive on 7-29-61, and that death occured at [illegible] AM, from the causes and on the date stated above.

22a. SIGNATURE M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — **22b. DATE SIGNED**

22c. PHYSICIAN'S NAME (Type): [illegible]

22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **23b. DATE THEREOF**: 8/2/61 — **23c. NAME OF CEMETERY OR CREMATORY**: River View Cemetery — **23d. LOCATION** (City, town or county) (State): Williamsport Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: AUG 3 '61 — **25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8502 **CERTIFICATE OF DEATH** 08496

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 219 Norway Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (C) Hagerstown
d. STREET ADDRESS: 219 Norway Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Susan Middle: Katherine Last: Derr

4. DATE OF DEATH: Month: July Day: 20, Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 10, 1875

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Kneisley

14. MOTHER'S MAIDEN NAME: Adaline Cover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: Mrs. Katherine Klinkhart, Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Coronary Atherosclerosis — 5 yrs

DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 19 59 to July 20, 19 61 that (I) (we) last saw the deceased alive on 6:30 AM 19 61 and that death occurred at 6:30 AM from the cause and on the date stated above.

22a. SIGNATURE: John D. Turco M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-21-61

22c. PHYSICIAN'S NAME (Type): Dr. John D. Turco

22d. ADDRESS: 302 N. Potomac St-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 7-22-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 24 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8503

CERTIFICATE OF DEATH

08497

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Martin Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived — If institution — Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 416 Mitchell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Anna — Middle Elizabeth — Last Eichelberger

4. DATE OF DEATH: Month July — Day 16 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 4, 1890

9. AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Milton Kershner

14. MOTHER'S MAIDEN NAME: Mary E. Cearfoss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. Hilda Barnes Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): general arteriosclerosis + cerebral thrombosis, Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 14, 1961 to July 16, 1961, that (I) (~~we~~) last saw the deceased alive on July 15 1961, and that death occurred at 3:45 P.M., from the causes and on the date stated above

22a. SIGNATURE: Edward W. Ditto III, M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/17/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D.

22d. ADDRESS: 217 West Washington St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-9-61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich, Son Hagerstown, md.

25a. REC'D BY REGISTRAR — DATE: JUL 20 '61

25b. REGISTRAR'S SIGNATURE: Cathryn L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film G290 7/14/61 iwk

CERTIFICATE OF DEATH

2504

Reg. Dist. No. 02493

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
d. STREET ADDRESS: 103 Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CORA Middle ELLEN Last EVERSOLE

4. DATE OF DEATH: Month July Day 7 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 5, 1885

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mid Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fulton County Penna.

12 CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Henry Robinette

14. MOTHER'S MAIDEN NAME: Jane E Beatty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph Montgomery Address: 103 Franklin St. Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO (b): MESENTERIC THROMBOSIS with gangrene of intestine — 48 hours

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1961, to July 7, 1961 19____, that I last saw the deceased alive on July 6, 1961, 19____, and that death occurred at 6:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H. Kehne M.D. ADDRESS (Street, city or town, state): DATE SIGNED: 7/7/61

PHYSICIAN'S NAME (Type): J. H. Kehne, M. D. 131 W. Washington St. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7.10.61

22c. NAME OF CEMETERY OR CREMATORY: Buck Valley Christian

22d. LOCATION (City, town, or county) (State): Buck Valley Fulton Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard J. Hines Hancock Md. ADDRESS

24a. REC'D BY REGISTRAR DATE JUL 11 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8505 — 09499

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown RFD
c. LENGTH OF STAY IN 1b: 3 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gateway Conv Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELI — Middle: WILLIAM — Last: FAHRNEY

4. DATE OF DEATH: Month: July — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARR.ED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 5 1870

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Funkstown Wash co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jeremiah Fahrney

14. MOTHER'S MAIDEN NAME: Cornida Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No —

16. SOCIAL SECURITY NO: none

17. INFORMANT — Address: Mrs Genevieve Shrader 23 E. Wash St Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterial Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO (b): Fracture

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture left hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell on floor May 10, 1961

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. May 10, 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Nursing Home — 20f. (City or town): Hagerstown — (County): Wash — (State): Md.

21. **I certify** that (I) (this hospital) attended the deceased from April 1, 1961 to July 9, 1961 that (I) (we) last saw the deceased alive on July 6, 1961, and that death occured at 2:55 P.M. from the causes and on the date stated above.

22a SIGNATURE: David R Brewer M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7/10/61

22c. PHYSICIAN'S NAME (Type): David R Brewer — 22d ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 7/11/61 — 23c. NAME OF CEMETERY OR CREMATORY: Funkstown cemetery — 23d. LOCATION (City, town or county): Funkstown — (State): Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew J. Coffman — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 12 '61 — 25b. REGISTRAR'S SIGNATURE: Charles S Kline

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8506 08500

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/61

M

I

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 45 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 16 Summer St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF (Type or print): First: Fred; Middle: Levern; Last: Fales Sr.

4. DATE OF DEATH: Month: July; Day: 19; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 16, 188[illegible]2

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance agent

10b. KIND OF BUSINESS OR INDUSTRY: Life Insurance

11. BIRTHPLACE (County & State, or foreign country): Ord, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Zacariah Fales

14. MOTHER'S MAIDEN NAME: Hattie Powers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-2219

17. INFORMANT: Mr. Milo C. Fales
Address: 1108 Sunnyside Dr. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage ht mill. cerebral only — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Arterio sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 351X — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arterio sclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 14 July, 1961 to 18 July, 1961, that (I) (we) last saw the deceased alive on 18 July 1961, and that death occured at 2[illegible] from the causes and on the date stated above.

22a. SIGNATURE: Eldon F. Hoachlander M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Eldon F. Hoachlander

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 22, 1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county): Hagerstown (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel
ADDRESS: Hagerstown, Md.
Wm. G. Hoak

25a. REC'D BY REGISTRAR DATE: JUL 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8507 — 28501

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 WKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY: Franklin
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle
d STREET ADDRESS: 26 N. Carlisle St
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia — Middle: F. — Last: Fletcher

4. DATE OF DEATH: Month: July — Day: 10 — Year: 1961

5 SEX: F.

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 29, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry A. Frary

14. MOTHER'S MAIDEN NAME: Julia Stanwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17 INFORMANT: Address: David W. Fletcher Jr. Hagerstown Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 wks.
DUE TO
(b): Arteriosclerotic cardiovascular disease — 20 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) [redacted] attended the deceased from 9-1-39 19 to 7-10-61 19, that (I) last saw the deceased alive on 7-10-61 19, and that death occurred at 5:45 am, from the causes and on the date stated above

22a SIGNATURE: W. C. Brewer M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7-10-61

22c PHYSICIAN'S NAME (Type): William C. Brewer, M.D.
22d ADDRESS: Greencastle, Pennsylvania

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: July 12, 1961
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Greencastle Franklin Co. Penna

24 FUNERAL DIRECTOR'S SIGNATURE: Harold W. Zimmerman
ADDRESS: Hagerstown Md
25a REC'D BY REGISTRAR DATE: JUL 13 '61
25b. REGISTRAR'S SIGNATURE: Wilma L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8503 Reg. Dist. No. 08502

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Yarrowsburg
d. STREET ADDRESS: Kaetzel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle DAVID — Last FOUCH

4. DATE OF DEATH: Month July — Day 16, — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 31, 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Refractory Plant

11. BIRTHPLACE (State or foreign country): Yarrowsburg, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN J. FOUCH

14. MOTHER'S MAIDEN NAME: SARAH WEST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 236-03-8917

17. INFORMANT: Mrs. Jeanette M. Fouch — Address: RFD # 1, Knoxville, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Posterior myocardial infarction

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 9, 19 61, to July 16, 19 61, that I last saw the deceased alive on July 16, 19 61, and that death occurred at 5:55 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin B Moody M.D. — ADDRESS (Street, city or town, state): 145 South Prospect Street, Hagerstown, Maryland — DATE SIGNED: 7/16/61

PHYSICIAN'S NAME (Type): Edwin B. Moody

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/19/61

22c. NAME OF CEMETERY OR CREMATORY: St.Luke's Cemetery

22d. LOCATION (City, town, or county) (State): Brownsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Harpers Ferry, West Va.

24a. REC'D BY REGISTRAR DATE JUL 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8509

CERTIFICATE OF DEATH

08503

1 PLACE OF DEATH a COUNTY: Washington — MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE: Md. b COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 1 week

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

d. STREET ADDRESS: 624 W. Franklin St., 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Jenny Middle: Mae Last: Fouche

4. DATE OF DEATH: Month: 7 Day: 22 Year: 19 61

5 SEX: female

6 COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: May 31, 1890

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Road Side, Pa.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Francis E. Hovis

14 MOTHER'S MAIDEN NAME: Esther Della

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-24-1609

17 INFORMANT: R. W. Fouche Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

903.0

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b) DUE TO

(c) Fracture Rt Tibia — 14th.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardio Sclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell While Standing on Curb.

20c. TIME OF INJURY Hour: o m p m Month, Day, Year: July 14 1961

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) Hagerstown (County) (State) Md.

21 **I certify** that (I) (this hospital) attended the deceased from July 15, 1961 to July 22, 1961, that (I) (we) last saw the deceased alive on July 22 1961 and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a SIGNATURE: J. H. Beachley M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. H. Beachley — 22d. ADDRESS: Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): burial

23b DATE THEREOF: 7-26-61

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City, town, or county): Hagerstown (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kraiss Funeral Home ADDRESS: Hagerstown, Md.

25a REC'D BY REGISTRAR DATE: JUL 27 '61

25b REGISTRAR'S SIGNATURE: Luther L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8510

CERTIFICATE OF DEATH

08504

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 122 FAIRVIEW DRIVE

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HANCOCK
d. STREET ADDRESS: 122 FAIRVIEW DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle ANDERSON — Last FRANCIS

4. DATE OF DEATH: Month 7 — Day 19 — Year 1961

5. SEX: MALE

6. COLOR OR RACE: BLACK

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4/20/1880

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): BEAVER CREEK, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. MARY BRUMBACK — Address: HANCOCK, MD. 122 FAIRVIEW DRIVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Stroke	3 days.
DUE TO (b)	Cerebral arteriosclerosis	10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerosis - generalized	20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 26 ..., 1959, to July 17 ..., 1961, that (I) (we) last saw the deceased alive on July 17 ..., 1961, and that death occured at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: F B Thomas III M.D.

M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-22-61

22c. PHYSICIAN'S NAME (Type): F. B. THOMAS III M.D.

22d. ADDRESS: HANCOCK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/22/61

23c. NAME OF CEMETERY OR CREMATORY: RIVERVIEW CEMETERY

23d. LOCATION (City, town or county) (State): HANCOCK, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone

ADDRESS: Hancock md

25a. REC'D BY REGISTRAR DATE: JUL 25 '61

25b. REGISTRAR'S SIGNATURE: Dallas S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8511 **CERTIFICATE OF DEATH** 08505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 235 E. Irvin Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: GEORGE — Middle: OTTEBEIN — Last: FUNKHOUSER

4. **DATE OF DEATH**: Month: July — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 22, 1907

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Representative

10b. KIND OF BUSINESS OR INDUSTRY: Advertising Co.

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Snapp Funkhouser

14. MOTHER'S MAIDEN NAME: Edith H. Snapp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-03-0140

17. INFORMANT: Mrs. Garnetta Funkhouser — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the lung with metastases — INTERVAL BETWEEN ONSET AND DEATH: 1½ yr.

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1 12:10 A. 59 to July 13 19 61 that (I) (we) last saw the deceased alive on July 12 19 61 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.

22b. DATE SIGNED: 7/14/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.

22d. ADDRESS: 148 West Washington Street Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/15/1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: B. Franklin Royer

ADDRESS: Suter - Rouser Funeral Home Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 '61

25b. REGISTRAR'S SIGNATURE: Carlton L. Hiams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8512

CERTIFICATE OF DEATH

08506

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 Mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1416 Potomac Ave

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 405 West Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROSE — Middle: (UNK) — Last: GALLO

4. DATE OF DEATH: Month: July — Day: 2 — Year: 1961

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Jany 24 1887 — 9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Own Home — 11. BIRTHPLACE (County & State, or foreign country): Rovita Italy — 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Antonio Lettiere — 14. MOTHER'S MAIDEN NAME: Louise (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Mrs Rose White 1416 Potomac Ave Hagerstown Md. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Ventricular fibrillation	5 m
DUE TO (b)	Acute myocardial infarction	18 hrs
DUE TO (c)	Coronary arteriosclerosis	Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March X, 1928 to July 2, 1961, that (I) (we) last saw the deceased alive on July 2 1961, and that death occured at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L L Parker Jr M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7/3/61

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 7/5/61 — 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — 23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE JUL 6 '61 — 25b. REGISTRAR'S SIGNATURE: Clifton S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8513 **CERTIFICATE OF DEATH** 38507

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN this place: 30 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 63 Armstrong Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle BRENT Last GLESNER

4. DATE OF DEATH: Month July Day 28 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jany 7 1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oil Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State or foreign country): Martinsburg Berkley Co Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob F. Glesner

14. MOTHER'S MAIDEN NAME: Margaret McLaughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): W.W.# 1

16. SOCIAL SECURITY NO.: 234-01-6192

17. INFORMANT: Mrs Hazel Glesner 93[illegible] Armstrong Ave Hagerstown Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2hrs
DUE TO (b): Generalized Atherosclerosis Syks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-27 19 61 to 7-28 19 61, that (I) (we) last saw the deceased alive on 7-28-61, and that death occured at 9:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: H E Bynkit

22b. DATE SIGNED: 7-31-61

22c. PHYSICIAN'S NAME (Type): H E Bynkit

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/31/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman

ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: AUG 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) M 9/60

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8514

CERTIFICATE OF DEATH

99503

TO BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TREGO - RURAL
c. LENGTH OF STAY IN 1b: 66 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KEEDYSVILLE MD. R.1

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X TREGO - RURAL
d. STREET ADDRESS: KEEDYSVILLE MD. R.1
a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First HARRY Middle MILTON Last GLOSS

4. **DATE OF DEATH**: Month JULY Day 23 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: JUNE - 14 - 1879

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months 1 Days 9 IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM.

11. BIRTHPLACE (County & State or foreign country): ANTIETAM WASH. Co. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. GLOSS

14. MOTHER'S MAIDEN NAME: MALINDA KEEDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MISS MAUDE GLOSS — Address: KEEDYSVILLE MD. R.1

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr

DUE TO (b) Generalized arteriosclerosis. — 5 Yr plus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 6, 1961 to July 23, 1961, that (I) (we) last saw the deceased alive on July 15, 1961, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 7/24/61.

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: July 26 1961

23c. NAME OF CEMETERY OR CREMATORY: ROHRERSVILLE CEMETERY

23d. LOCATION (City, town or county) (State): ROHRERSVILLE WASH. Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John D. Boot — ADDRESS: BOONSBORO MD.

25a. REC'D BY REGISTRAR DATE: JUL 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2515 — 08509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

1. PLACE OF DEATH
   a. COUNTY: Washington
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: Life (MARYLAND)
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 18 Dunn Irvin Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David; Middle: William; Last: Gossard

4. DATE OF DEATH: Month: July; Day: 19; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours: 15, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William S. Gossard

14. MOTHER'S MAIDEN NAME: Kathleen E. Schleigh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: William S. Gossard — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): 7625
- DUE TO (b): atelectasis
- DUE TO (c): prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/19, 1961, to 7/19, 1961, that (I) (we) last saw the deceased alive on 7/19 1961, and that death occured at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/20/61

22c. PHYSICIAN'S NAME (Type): HARRY D. BOWMAN, MD

22d. ADDRESS: 318 N. Potomac St. Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/20/1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Maryland MD

24 FUNERAL DIRECTOR'S SIGNATURE: R. Franklin Rouzer

Suter & Rouzer Funeral Home ADDRESS Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE JUL 24 '61

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3515 — Reg. Dist. No. 0850

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dargan
d. STREET ADDRESS: RFD#1, Harpers Ferry, W.Va.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEONA — Middle CATHERINE — Last GRIM

4. DATE OF DEATH: Month July — Day 6, — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 12, 1922

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dietician

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Rohrersville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Flook

14. MOTHER'S MAIDEN NAME: Katie Haines

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: 215-34-3511

17. INFORMANT: Mr. Weller Grim — Address: RFD # 1, Harpers Ferry, West Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
171X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis L Kidney

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to July 6, 1961, that I last saw the deceased alive on July 5, 1961, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S F Waddill M.D. — ADDRESS (Street, city or town, state): 115 King St. Hagerstown, Md. — DATE SIGNED: 7-6-61

PHYSICIAN'S NAME (Type): Samuel F. Waddill — 115 King St. Hagerstown, Md. 7-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/9/61
22c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cemetery
22d. LOCATION (City, town, or county) (State): Samples Manor, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Harpers Ferry, W.Va.

24a. REC'D BY REGISTRAR DATE: JUL 17 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9 & 14 filled 8/8/61 iwk

CERTIFICATE OF DEATH

8517 Reg. Dist. No. 0851

1. PLACE OF DEATH
a. COUNTY: Washington, Ft Ritchie, Cascade MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Ritchie, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US ARMY DISPENSARY, FT RITCHIE, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Ritchie, Maryland
d. STREET ADDRESS: Bldg. 451 Apt. #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle LAIRD Last HANNEN

4. DATE OF DEATH: Month July Day 31 Year 19 61

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12 Oct 1919

9. AGE (In years last birthday): 41 / 42 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Specialist

10b. KIND OF BUSINESS OR INDUSTRY: US ARMY

11. BIRTHPLACE (State or foreign country): Cliftonsville, W. Va.

12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: CHARLES HANNEN

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): To present

16. SOCIAL SECURITY NO.: 1295-10-5177

17. INFORMANT: Address: From Army Records by WILLIAM T CUZICK Capt, MSC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 20-25min

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): None

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 28 July, 19 61, and that death occurred at 0510AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Patrick J Ferraro capt MC, M.D. ADDRESS (Street, city or town, state): Fort Ritchie, Cascade, Maryland DATE SIGNED: 31 Jul 61

PHYSICIAN'S NAME (Type): PATRICK J FERRARO, CAPT., MC Fort Ritchie, Md. US ARMY DISPENSARY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/3/1961
22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
22d. LOCATION (City, town, or county) (State): Steubenville, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: L. Martin Poe, ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: AUG 3 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8518 — 08512

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
e. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owensville
d STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Ellsworth — Last: Hardesty
4. DATE OF DEATH: Month: 7 — Day: 31 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 3, 1878
9. AGE (In years last birthday): 82 81 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Tabocca
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Richard H. Hardesty
14. MOTHER'S MAIDEN NAME: Sarah Faust
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: none — Address: Mr Andrew Sothoron-118 9th St. N.E. Washington, D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 201 X Hodgkin's disease — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2Da. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19
2Dd INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County, (State)

21. I certify that (I) (this hospital) attended the deceased from April 24 19 61 to July 31 19 61, that (I) (we) last saw the deceased alive on July 31 19 61, and that death occured at 10:15 A.M. from the causes and on the date stated above.

22e SIGNATURE: Young E. Chun M.D — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] — 22b. DATE SIGNED: July 31 1961
22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN
22d ADDRESS: 1500 Penna. Ave. Hagerstown, Md

23a. BURIAL, CREMATION REMOVAL (Specify): Burial — 23b. DATE THEREOF: August 2, 61
23c. NAME OF CEMETERY OR CREMATORY: Mt Harmony Cemetery
23d. LOCATION (City, town or county) (State): Calvert County, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Hutchens Funeral Home — ADDRESS: Owings, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 3 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8513 08513

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14½ years
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 230 Clearview Road
d. STREET ADDRESS: 230 Clearview Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha Middle: Anna Last: Heinzman
4. DATE OF DEATH: Month: M July Day: 6, Year: 19 61

5 SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: March 9, 1878
9 AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): Reading Penna.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel J. Heckman;
14. MOTHER'S MAIDEN NAME: Margaret Auge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 187-10-3421
17. INFORMANT — Address: Mrs. Ruth Moulden, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): arteriosclerosis — 1 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 29, 19 61 to July 3, 19 61 that (I) (we) last saw the deceased alive on July 3 19 61, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Howard N. Weeks M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.
22d ADDRESS: 136 N. Potomac St.

23a BURIAL, CREMATION, REMOVAL (Specify): burial
23b DATE THEREOF: 7-8-61
23c NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery
23d. LOCATION (City, town, or county) (State): Winchester, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
25a REC'D BY REGISTRAR — DATE: JUL 10 '61
25b REGISTRAR'S SIGNATURE: Arthur J. Krumb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8520 Reg. Dist. No. 08514

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRVIEW KEEDY MEM. HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: W. WASHINGTON ST. EXT.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle ELLEN — Last HIXON

4. DATE OF DEATH: Month JULY — Day 5 — Year 19 61

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/6/1884
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM A. ZULLINGER
14. MOTHER'S MAIDEN NAME: ELLEN JANE RISE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: MR. RAYMOND Z. HIXON — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertension Cardio - Vascular
DUE TO (b): Fracture
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o m. p. m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from January 7, 1961 to July 5 61, 19, that I last saw the deceased alive on July 5 1961, 19, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Boonsboro — DATE SIGNED: 7/6/61

PHYSICIAN'S NAME (Type): G. Wilson Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/8/61
22c NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: JUL 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Hewitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8521

CERTIFICATE OF DEATH

08515

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hopital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d. STREET ADDRESS: Route 4
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Elmer — Last: Hoffman

4. DATE OF DEATH: Month: July — Day: 27 — Year: 19 61

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: Nov. 5, 1915 — 9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk — 10b. KIND OF BUSINESS OR INDUSTRY: Furniture — 11. BIRTHPLACE (City or State or foreign country): Mt. Savage, Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elmer Hoffman — 14. MOTHER'S MAIDEN NAME: Carrie Hyde

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mrs. Jane Hoffman — Address: Rt. 4 Hag. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 3 1 X — DUE TO: Subarachnoid Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — (b): Congenital malformation of blood vessels in Brain — DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH: 9 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work [ ] Not While at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or Town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 24 19 61, to July 27 19 61, that (I) (we) last saw the deceased alive on July 27 19 61, and that death occured at 12:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D. — 22b. DATE SIGNED: 7/28/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 7-30-61 — 23c. NAME OF CEMETERY OR CREMATORY: Long Meadow Cemetery — 23d. LOCATION (City, town or county) (State): Paramount Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE JUL 31 '61 — 25b. REGISTRAR'S SIGNATURE: Arling S. Krause

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8522

CERTIFICATE OF DEATH

Reg. Dist. No. 08510

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Conv. Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mercersburg, Penna.
d. STREET ADDRESS: 131 W. Seminary St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWIN — Middle — Last HOFFMAN
4. DATE OF DEATH: Month July — Day 1, — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/4/1880
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman
10b. KIND OF BUSINESS OR INDUSTRY: Investments
11. BIRTHPLACE (State or foreign country): New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Hoffman
14. MOTHER'S MAIDEN NAME: Isabella Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Edwin Hoffman — Address: Mercersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma, Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mo +
DUE TO
153.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 June, 1961, to 1 July, 1961, that I last saw the deceased alive on 29 Jun, 1961, and that death occurred at 1045 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Fusby M.D. — ADDRESS (Street, city or town, state): 230 N Potomac St Hagerstown Md — DATE SIGNED: 3 July 61
PHYSICIAN'S NAME (Type): F F Fusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/4/61
22c. NAME OF CEMETERY OR CREMATORY: Fairview Cem.
22d. LOCATION (City, town, or county) (State): Mercersburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: J. M. Geringer — ADDRESS: Mercersburg, Pa.
24a. REC'D BY REGISTRAR DATE: Jul 5 '61
24b. REGISTRAR'S SIGNATURE: [illegible] Home

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8523

CERTIFICATE OF DEATH

98517

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 19 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: WASH.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1054 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle EMMETT — Last IRWIN

4. DATE OF DEATH: Month 7 — Day I — Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 10, 1888

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: MOLLER ORGAN WORKS

11. BIRTHPLACE (State or foreign country): VIRIGINA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY H. IRVIN

14. MOTHER'S MAIDEN NAME: EMMA SUPINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): 1910- 1914

16. SOCIAL SECURITY NO.: 220-16-0669

17. INFORMANT: MRS. PAULINE IRVIN — Address: 1054 S.POTOMAC ST. HAGERSTOWN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 MIN.
DUE TO (b): Hypertensive Cardio-Vascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) - (County) - (State) -

21. I certify that (I) (this hospital) attended the deceased from March 1, 1961, to July 1, 1961, that (I) (we) last saw the deceased alive on July 1 19 61, and that death occurred at P M, from the causes and on the date stated above

22a. SIGNATURE: M Turco — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-3-61

22c. PHYSICIAN'S NAME (Type): Dr. John D. Turco

22d. ADDRESS: 302 N. Potomac Street-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/5/1961

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL

23d. LOCATION (City, town, or county) (State): HAGERSTOWN, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: KRESS FUNERAL HOME — ADDRESS: HAGERSTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUL 7 '61

25b. REGISTRAR'S SIGNATURE: Chas L. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8524 — 99518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 207 N. Mulberry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Nora — Middle: Rose — Last: Kipe

4. **DATE OF DEATH**: Month: July — Day: 13 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1896

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Sabina, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: Mr. Lewis Kipe 207 N. Mulberry St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Partial Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 30 days

DUE TO (b): Intra-abdominal Metastasis from Epidermoid Carcinoma of the Cervix — 30 days

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 171 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe generalized osteoarthritis (Epidermoid carcinoma of cervix grade III treated July 1954)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~XXXXXX~~) attended the deceased from June 14 1961 to July 13, 1961, that (I) (~~XX~~) last saw the deceased alive on July 13 1961, and that death occured at 3:15 pm, from the causes and on the date stated above.

22a. SIGNATURE: W. T. Layman M.D.

22b. DATE SIGNED: 7-14-61

22c. PHYSICIAN'S NAME (Type): W. T. Layman, M.D.

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 100 Professional Arts Bldg. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

Wm. C. Hook

25a. REC'D BY REGISTRAR — DATE: JUL 17 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8525

CERTIFICATE OF DEATH

08519

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Md. State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport ♡ 143-2
d. STREET ADDRESS: 70 Walnut
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Hetzel Last: KLINE

4. DATE OF DEATH: Month: JULY Day: 6 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 7, 1901

9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kline

14. MOTHER'S MAIDEN NAME: Sarah Saville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-16-3764

17. INFORMANT: Mrs. Ray Guy Address: Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): BILATERAL LOBULAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE-UNKN

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SEROFIBRINOUS PERICARDITIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 4-26-61, 1961, to 7-6-, 1961, that (I) (~~saw~~) last saw the deceased alive on 7-6- 1961., and that death occured at 3:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Antonio U. Pallagrosi M.D

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI

22d. ADDRESS: 1500 PENNA AVE HAGERSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 7/10/61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Philos Cem

23d. LOCATION (City, town or county): Westernport (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E.S. Boal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: Clifford L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8528

CERTIFICATE OF DEATH

08520

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 847 Virginia Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theresa — Middle: Marie — Last: Kline

4. DATE OF DEATH: Month: 7 — Day: 26 — Year: 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-26-61

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours: 3 | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10b. KIND OF BUSINESS OR INDUSTRY: infant

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Kline

14. MOTHER'S MAIDEN NAME: Mary Warrenfeltz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Kline — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 761 - Fatal Anemia

DUE TO (b): Immaturity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): None

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) - (County) - (State) -

21. I certify that (I) (this hospital) attended the deceased from - 19- to - 19-, that (I) (we) last saw the deceased alive on - 19-, and that death occurred at -M, from the causes and on the date stated above.

22a. SIGNATURE: John D Turco M D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-28-61

22c. PHYSICIAN'S NAME (Type): Dr. John D. Turco

22d. ADDRESS: 302 N. Potomac St-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/28/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City town, or county) (State): Hagerstown Md

24. FUNERAL DIRECTOR'S SIGNATURE: Sutter Keyser Funeral Home — ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR DATE: AUG 9 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8527

CERTIFICATE OF DEATH

C8521

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MARYLAND STATE HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 509 FURNACE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

791

I

3 NAME OF DECEASED (Type or print): First: Anna — Middle — Last: Klitsch

4 DATE OF DEATH: Month: July — Day: 5 — Year: 1961

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: OCT. 4, 1893
9 AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b KIND OF BUSINESS OR INDUSTRY: SELF
11 BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GOTTLIEB KLITSCH
14. MOTHER'S MAIDEN NAME: WLIZABETH WIEGAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16 SOCIAL SECURITY NO.: NONE
17 INFORMANT — Address: MARGARET A. DEAN — CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Lobular Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: one week

DUE TO (b): Carcinoma of breast with Metastasis to pleura and pericardium — 6 years

DUE TO (c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour a. m. p. m — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 **I certify** that (I) (~~this hospital~~) attended the deceased from June 23, 1961 to July 5, 1961, that (I) (we) last saw the deceased alive on July 5, 1961, and that death occurred at 5:35 P.M. from the causes and on the date stated above.

22a SIGNATURE: Young E. Chun M.D
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: July 5 1961
22c PHYSICIAN'S NAME (Type): YOUNG E. CHUN
22d ADDRESS: Western Maryland State Hospital, Hagerstown, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JULY 7, 1961
23c NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
23d. LOCATION (City, town, or county) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a REC'D BY REGISTRAR DATE: JUL 10 '61
25b REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8528 **CERTIFICATE OF DEATH** 8522

1. **PLACE OF DEATH**
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 2
c. LENGTH OF STAY IN 1b: 85 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cavetown Pike

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 2
d. STREET ADDRESS: Cavetown Pike
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: EMLA Middle: AMELIA Last: KRETSINGER
4. DATE OF DEATH: Month: July Day: 20 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct 5 1875
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Chewsville Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John W. Beard
14. MOTHER'S MAIDEN NAME: Sarah Baechtel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO: --
17. INFORMANT: None
Address: Mrs Beulah Hoover Smithsburg R # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — Greensburg — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — 331 X — 20 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-16 19 56 to 7-20 19 61, that (I) (we) last saw the deceased alive on 7-20 19 61, and that death occured at 10:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7-21-61
22c. PHYSICIAN'S NAME (Type): Charles F. Hess
22d. ADDRESS: Smithsburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/23/61
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery Mausoleum
23d. LOCATION (City, town or county) (State): Smithsburg Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8529

CERTIFICATE OF DEATH

8529

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DR. HARRISON
318 N. POTOMAC ST.

I

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
d. STREET ADDRESS: BOONSBORO MD. R.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle ALBERT Last LEGGETT

4. DATE OF DEATH: Month JULY Day 17 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 22 - 1858

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months 11 Days 25 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): BOONSBORO WASH. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM LEGGETT

14. MOTHER'S MAIDEN NAME: SARAH PARKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: WILLIS E. LEGGETT Address: BOONSBORO MD. R.2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO (b): CEREBRAL ARTERIOSCLEROSIS — ?

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 9, 1961 to July 17, 1961, that (I) (we) last saw the deceased alive on July 16, 1961, and that death occured at 6.45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/18/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY. 19. 1961

23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

23d. LOCATION (City, town or county) (State): BOONSBORO WASH. Co. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John W. Bast ADDRESS: BOONSBORO MARYLAND

25a. REC'D BY REGISTRAR DATE JUL 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8530

CERTIFICATE OF DEATH

09525

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R.F.D.
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gateway Conv Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 308 No Potomac St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First SAMUEL Middle LUTHER Last LUMM

4. **DATE OF DEATH**: Month July Day 28 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 1 1876

9. AGE (In years last birthday): 84 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Mt Lena Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther Lumm

14. MOTHER'S MAIDEN NAME: Mary McKinzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of serv.ce): --

16. SOCIAL SECURITY NO.: 220-09-7572

17. INFORMANT: David R. Lumm

Address: 208 No Potomac St

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arterio Sclerotic Heart Dis — 5 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 15, 1961 to July 28, 1961 that (I) (we) last saw the deceased alive on July 28 1961 and that death occured at 7:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David R. Brewer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/30/61

22c. PHYSICIAN'S NAME (Type): David R. Brewer

22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/31/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: AUG 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Items 18&20 Film 292

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08525

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Williamsport
   c. LENGTH OF STAY IN 1b: unknown hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
   d. STREET ADDRESS: 309 S Montvalla Ave. 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Norman — Middle: Wilbert — Last: Malott

4. **DATE OF DEATH**: Month: July — Day: 21 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 2 1922

9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months 6 Days 18 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: House Contractor

11. BIRTHPLACE (State or foreign country): Williamsport Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Edward Malott

14. MOTHER'S MAIDEN NAME: Letha Wiley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214 14 6217

17. INFORMANT: Mrs. Mary Louise Malott — Address: 309 S. Montvalla Av Hagerstown Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Drowning~~ Drowning
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Instant

929.8

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Found floating in Potomac River.

20c. TIME OF INJURY: Hour 5 p.m. Month, Day, Year 7-21- 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac River

20f. (City or town) Williamsport (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. W. Ditto Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

NAME (Type): Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

DATE SIGNED: July 22, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 24-61

22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

22d. LOCATION (City, town, or country): Williamsport (State) Maryland

23. FUNERAL DIRECTOR: Abner Bitto — ADDRESS: Williamsport, Md.

24a. REC'D BY REGISTRAR DATE: JUL 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

VS. A1SME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8532 — 08526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagers town
d. STREET ADDRESS: 704 No Mulberry St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ALLEN — Middle: — Last: LARCONI

4. **DATE OF DEATH**: Month: July — Day: 28 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 2 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (County & State, or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Larconi

14. MOTHER'S MAIDEN NAME: Jacklyn Gelwicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Thomas Marconi — Address: 704 No Mulberry St Hagerstown Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (28 wks)
DUE TO (b): 776 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 26, 1961 to July 28, 1961, that (I) (we) last saw the deceased alive on July 28 1961, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-29-61

22c. PHYSICIAN'S NAME (Type): PAUL HARRISON, M. D.

22d. ADDRESS: 513 N. POTOMAC ST., HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/29/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: AUG 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8533 **CERTIFICATE OF DEATH** C8527

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d STREET ADDRESS: 247 WINTER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSE Middle WILLIAM Last MARTIN

4. DATE OF DEATH: Month JULY Day 14 Year 19 61

5 SEX: MALE

6. COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 13 1891

9 AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABORER

10b. KIND OF BUSINESS OR INDUSTRY: MUNICIPAL EMP.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN J. MARTIN

14. MOTHER'S MAIDEN NAME: ANNA C. FOUCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: 214-09-6553

17. INFORMANT: MRS. MARGARET V. HOWLETT Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ac Myocardial Infarction — DUE TO

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 7/14/61, 19__, to 7/14/61, 19__, that (I) (we) last saw the deceased alive on 7/14/61 19__, and that death occurred at 4:00 PM, from the causes and on the date stated above.

22a SIGNATURE: Ralph F Young M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 7/16/61

22c PHYSICIAN'S NAME (Type): RALPH F YOUNG.

22d. ADDRESS: Williamsport, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/17/61

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

23d LOCATION (City, town or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. J. Hormut, Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8534 — 00523

1 PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg
d. STREET ADDRESS: 15 S. Maple Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Effie — Middle: May — Last: Masters

4. DATE OF DEATH: Month: July — Day: 18, — Year: 19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
female	white		January 4, 1869	92 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Greensburg, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Reynolds	Lydia Stephey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	Charles D. Masters, Smithsburg, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Valvular Heart Disease	10 yrs.
DUE TO (b)	Generalized Arteriosclerosis	20 yrs.
DUE TO (c)	Senility	20 yrs.

421.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-26-60 19___ to 7-17-61 19___, that (I) (we) last saw the deceased alive on 7-17-61 19___, and that death occurred at 10:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 7-1-61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess, M. D. — 22d. ADDRESS: Smithsburg, Maryland

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
burial	7-21-61	Smithsburg Cemetery	Smithsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Scott F. Minnich & Son, Smithsburg, Md.	JUL 21 '61	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

FOR STATE HEALTH DEPT.

M

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3535 — 68529

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: MARYLAND — 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: WEST VA.
b. COUNTY: BERKELEY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARTINSBURG
d. STREET ADDRESS: 309 East John St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SALLY — Middle B. — Last MILLS

4. DATE OF DEATH: Month JULY — Day 11 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 15, 1915

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Duties

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Breeden

14. MOTHER'S MAIDEN NAME: Nora Breeden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: James H. Mills (Husband) — Address: 309 E. John St. Martinsburg W. Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SUBDURAL HEMATOMA, RIGHT PARIETAL MINIMAL — INTERVAL BETWEEN ONSET AND DEATH: RECENT

DUE TO (b): SUBDURAL HEMATOMA, TEMPORAL & FRONTAL, OLD — RECENT

DUE TO (c): CEREBRAL EDEMA MODERATE — RECENT

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PULMONARY EMBOLUS, LEFT

FATTY CHANGE, LIVER

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/12/61

EXAMINER'S NAME (Type): E.W.DITTO, JR. M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-14-1961

22c. NAME OF CEMETERY OR CREMATORY: Tuscarora Cemetery

22d. LOCATION (City, town, or country): Martinsburg Rt. # 1 (Berkeley County) (State): W. Va.

23. FUNERAL DIRECTOR: H. K. Brown — ADDRESS: Martinsburg, W. Va.

24a. REC'D BY REGISTRAR (DATE): JUL 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8535 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 02530

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 1, BIG SPRING
c. LENGTH OF STAY IN 1b: 3 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 1, BIG SPRING, MD.
d. STREET ADDRESS: ROUTE 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First SARAH — Middle ANN — Last MILLS

4. DATE OF DEATH: Month JULY — Day 20 — Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 20, 1872

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months 1 — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: HOME DUTIES

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAKE MANAN

14. MOTHER'S MAIDEN NAME: ELIZEBETH MILLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: FRANK MILLS — Address: ROUTE 1, BIG SPRING, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO (b): Senility
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a. m. p. m. — Month, Day, Year 19__

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. W. Dutton Jr. M.D.
EXAMINER'S NAME (Type): J. E. W. Dutton Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7/24/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JULY 22, 1961
22c. NAME OF CEMETERY OR CREMATORY: PARK HEAD CEMETERY
22d. LOCATION (City, town, or county) (State): PARKHEAD, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: M. R. Rowland, ADDRESS: CLEAR SPRING, MD.

24c. REC'D BY REGISTRAR DATE: JUL 24 '61

24d. REGISTRAR'S SIGNATURE: Arthur L. Hawes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the chief medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8537 **CERTIFICATE OF DEATH** 08531

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 35 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 478 Mitchell Ave.
d. STREET ADDRESS: 478 Mitchell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virgil Middle: George Last: Montgomery
4. DATE OF DEATH: Month: July Day: 3, Year: 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 19, 1916
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cabinet maker
10b. KIND OF BUSINESS OR INDUSTRY: organ factory
11. BIRTHPLACE (State or foreign country): Smithsburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Montgomery
14. MOTHER'S MAIDEN NAME: Nannie R. Wade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes WW II
16. SOCIAL SECURITY NO: 214-09-4502
17. INFORMANT Address: Mrs. Lillian Montgomery, Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Dilatation (assumed) — INTERVAL BETWEEN ONSET AND DEATH: 15-30 minutes.

DUE TO (b): Cardiac Hypertrophy Tricuspid Stenosis — 30 days certain

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this physician~~) attended the deceased from June 3 1961 to 2:30 pm July 3 1961, that (I) (We) last saw the deceased alive on July 1 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: W. T. Layman M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7-5-61
22c. PHYSICIAN'S NAME (Type): W. T. Layman, M.D.
22d. ADDRESS: 100 Professional Arts Bldg. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 7-6-61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: JUL 7 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8538

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: WASHINGTON
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. LENA - RURAL
   c. LENGTH OF STAY IN 1b: 15 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO MD. R.2

2. **USUAL RESIDENCE** (Where deceased lived. If institutional resident, give usual address.)
   a. STATE: MARYLAND
   b. COUNTY: WASHINGTON
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. LENA - RURAL
   d. STREET ADDRESS: BOONSBORO MD. R.2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES Middle E. Last MORGAN

4. **DATE OF DEATH**: Month JULY Day 12 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 15 1871

9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months 10 Days 27 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (County & State or foreign country): ANTIETAM WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE MORGAN

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: HUBERT W. MORGAN Address: BOONSBORO MD. R.2

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hydronephrosis & Pyelonephritis	Months
DUE TO (b)	Anemia - Secondary	Months
DUE TO (c)	Prostate Hypertrophy	4 years.

610X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): Blood Pressure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 8, 1961, to July 12, 1961, that (I) (we) last saw the deceased alive on July 12 1961, and that death occured at 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/14/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: July-15-1961

23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

23d. LOCATION (City, town or county) (State): BOONSBORO WASH. CO. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John H. Bast ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE JUL 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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Dr. Hirshman
159 W. Wash. St.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8539

CERTIFICATE OF DEATH

68533

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): C3 Hagerstown
d. STREET ADDRESS: 810 W. Washington St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pauline Middle: Alice Last: Myers

4. DATE OF DEATH: Month: 7 Day: 27 Year: 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 4, 1889

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Three Rivers, Canada

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Philip M. Conner

14 MOTHER'S MAIDEN NAME: Mary Heist

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17 INFORMANT: Robert C. Myers Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 11/15, 19 60 to 7/27, 19 61 that (I) (we) last saw the deceased alive on 7/27, 19 61, and that death occurred at 12 M, from the causes and on the date stated above.

22a. SIGNATURE: Howard N. Weeks M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/28/61

22c PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D.

22d. ADDRESS: 136 N. Potomac St.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 7-30-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City, town, or county) (State): Hagerstown Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Margaret K. Rowland ADDRESS: Clear Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUL 31 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8540

CERTIFICATE OF DEATH

58534

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 29 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hospital.,

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville.,
   d. STREET ADDRESS: 210 Lincoln Ave.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jackson — Last: Palmer

4. DATE OF DEATH: Month: July — Day: 16 — Year: 1961

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1897

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Jackson

14. MOTHER'S MAIDEN NAME: Liza Ann Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Elizabeth Jackson: 210 Lincoln Ave, Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobular pneumonia
DUE TO (b): Cerebral vascular thrombosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) 4 days; (b) Some yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 26, 1961 to July 16, 1961, that (I) (we) last saw the deceased alive on July 16, 1961, and that death occured at 9:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Victor L Parnes M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: July 16, 1961

22c. PHYSICIAN'S NAME (Type): Victor L Parnes, M.D.

22d. ADDRESS: Western Maryland State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/19/61
23c. NAME OF CEMETERY OR CREMATORY: St. Rose's,
23d. LOCATION (City, town or county) (State): Cloppers, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Burnley
ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: JUL 20 '61
25b. REGISTRAR'S SIGNATURE: Orlin L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8541 **CERTIFICATE OF DEATH** 08535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN this MARYLAND place: 24 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 148 Greenberry Road

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 118 East Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SARAH Middle: PAMELIA Last: POTTER

4. **DATE OF DEATH**: Month: July Day: 25 Year: 1961 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 18 1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Rohrersville Wash Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Silas H. Norris

14. MOTHER'S MAIDEN NAME: Margaret Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Catherine Smith 59 Main St Keedysville Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4210

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 24, 1961 to July 25, 1961, that (I) (we) last saw the deceased alive on July 25 1961, and that death occured at 12:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E L Parker M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/26/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/27/61

23c. NAME OF CEMETERY OR CREMATORY: Rohrersville Cemetery

23d. LOCATION (City, town or county) (State): Rohrersville Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman

ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 27 '61

25b. REGISTRAR'S SIGNATURE: Evelyn L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8542 — 68536

TO HOLD BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 6
d. STREET ADDRESS: Sunrise Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: WILLIAM — Last: RALLS

4. DATE OF DEATH: Month: July — Day: 15 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 31 1898

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stereotype operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Montgomery Co Front Royal W. Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Ralls

14. MOTHER'S MAIDEN NAME: Catherine Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 220-10-3200

17. INFORMANT — Address: Mrs Ella I. Ralls 206 Monongalia St Charleston W. Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio vascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: min

DUE TO (b): Pulmonary Fibrosis — hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Anemia cordis — Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema Lungs

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 13, 1961, to July 15, 1961, that (I) ~~(the)~~ last saw the deceased alive on July 15, 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Craft M.D.

22b. DATE SIGNED: 7/17/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Louis G. Craft

22d. ADDRESS: 119 E. Antietam

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/17/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR — DATE: JUL 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8543 Reg. Dist. No. 22537

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RT#2 HAGERSTOWN CONOCOCHEAGUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL HAGERSTOWN
d. STREET ADDRESS: RT.#2 HAGERSTOWN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DEBORAH Middle KAY Last RAUTH

4. DATE OF DEATH: Month JULY Day 30 Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/24/1956

9. AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT V. RAUTH

14. MOTHER'S MAIDEN NAME: CATHERINE IRENE SHOWE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MR. ALBERT V. RAUTH Address: RT#2 HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned While playing in Conococheague Creek

20c. TIME OF INJURY Month, Day, Year: Hour 6:10 a.m. p.m. 7—30 1961

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Creek

20f. (City or town) Hagerstown (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: July 31, 1961

EXAMINER'S NAME (Type): Dr. E. W. Ditto, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/2/61
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment ADDRESS: Hagerstown Md
24a. REC'D BY REGISTRAR DATE: AUG 3 '61
24b. REGISTRAR'S SIGNATURE: Clinton L. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1 4

FOR STATE HEALTH DEPT.

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08533

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: MARYLAND / MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - ROUTE 1
d. STREET ADDRESS: BOONSBORO MD. R.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle LUTHER Last REEDER

4. DATE OF DEATH: Month JULY Day 23 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY-27-1915

9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months Days 4 26 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TOOL AND DIE MAKER

10b. KIND OF BUSINESS OR INDUSTRY: FAIRCHILD AIRCRAFT

11. BIRTHPLACE (State or foreign country): BENEVOLA WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HUBERT E. REEDER

14. MOTHER'S MAIDEN NAME: ALICE R. HUTZELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 213-12-7216

17. INFORMANT: MRS. MARY REEDER Address: BOONSBORO MD. R.2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b): Arteriosclerotic heart Disease — recent
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from / Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Dr. E. [illegible] Di[illegible]o, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: July 24, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JULY 25 1961

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or country) (State): BOONSBORO WASH. Co. MD.

23. FUNERAL DIRECTOR: John D. Bast ADDRESS: BOONSBORO MD.

24a. REC'D BY REG.STRAR DATE: JUL 28 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8545 — 22539

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1131 Hamilton Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Jackson — Last: Robinson

4. DATE OF DEATH: Month: July — Day: 8 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 4, 1908

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Retail- Tires

11. BIRTHPLACE (State or foreign country): Marion, Va.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: W. S. Robinson

14. MOTHER'S MAIDEN NAME: Cora Tucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-09-1109

17. INFORMANT: Address: Mrs. Eleanor Robinson Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Nephrosclerosis - with uremia — INTERVAL BETWEEN ONSET AND DEATH: unks

442 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive cardiovascular disease — 2 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple pulmonary emboli

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1959 to July 198, that (I) (we) last saw the deceased alive on July 7 1961, and that death occurred at 1:30a M, from the causes and on the date stated above.

22a SIGNATURE: Ralph S. Stamper, M.D. by John C. Stamper M D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED:

22c PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-10-61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d LOCATION (City, town, or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son

ADDRESS: Hagerstown, md.

25a. REC'D BY REGISTRAR DATE: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2545 — 98540

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Berkeley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Martinsburg
d. STREET ADDRESS: 218 West Martin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Lafeyette — Last: Rosser

4. DATE OF DEATH: Month: July — Day: 2, — Year: 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 21 Nov. 1867
9. AGE (In years last birthday): 93 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: carpenter
11. BIRTHPLACE (State or foreign country): Harrisonburg, Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Rosser
14. MOTHER'S MAIDEN NAME: Susan Beeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Mina Durr, 218 W. Martin Str. — Address: Martinsburg, W.Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 40 yrs -
DUE TO
450.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, Prostatitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1961, to July 2 1961, that (I) (we) last saw the deceased alive on June 15 1961, and that death occurred at 5:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: F. A. Hamilton — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: July 3, 1961
22c. PHYSICIAN'S NAME (Type): F. A. Hamilton
22d. ADDRESS: Winchester Ave. Martinsburg W.Va

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5 July 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Thomas, Tucker, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Estate V. Teal — ADDRESS: Williamsport Maryland
25a. REC'D BY REGISTRAR: DATE JUL 5 '61
25b. REGISTRAR'S SIGNATURE: Clifton B. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8547 — 8547

TO HOSPITAL ■■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN 13
d. STREET ADDRESS: 1042 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLYDE — Middle SYLVESTER — Last SHANK

4. DATE OF DEATH: Month JULY — Day 13 — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/31/1885

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CLERK

10b. KIND OF BUSINESS OR INDUSTRY: FEED STORE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BARRY O. SHANK

14. MOTHER'S MAIDEN NAME: BARBARA SUMMERS

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-0220

17. INFORMANT: MRS. LELIA H. SHANK — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive and Arteriosclerotic Heart Disease — 7 months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pancytopenia; arthritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from June 29 1961, to July 13 1961, that (I) ~~XXX~~ last saw the deceased alive on July 13 1961, and that death occurred at 11:15 pm M, from the causes and on the date stated above

22a. SIGNATURE: W. T. Layman, M.D. — M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-15-61

22c. PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22d. ADDRESS: 100 Professional Arts Bldg. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/16/61

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: A. J. Normen, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Price

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2548 Item 9 Film 0292 7/21/61 iwk 98542

1 PLACE OF DEATH a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN, MD.
c. LENGTH OF STAY IN 1b: 3 WKS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON CO. HOSPITAL

2 USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission) a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 1 CLEAR SPRING, MD.
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First ELIZEBETH — Middle ELLEN — Last SHINGLETON
4. DATE OF DEATH: Month JULY — Day 22, — Year 1961

5 SEX: FEMALE — 6 COLOR OR RACE: WHITE — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: OCT. 12, 1888 — 9 AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: HOME DUTIES
11 BIRTHPLACE (State or foreign country): ROMNEY W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H. HAINES
14. MOTHER'S MAIDEN NAME: LUCRETIA SHANK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17 INFORMANT: WARREN S. SHINGLETON — Address: ROUTE1, CLEAR SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): a. Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
4-01
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d INJURY OCCURRED White at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 7/22/61 19 to 7/22/61 19, that (I) (we) last saw the deceased alive on 7/22/61 19, and that death occurred at 3:50 P.M. from the causes and on the date stated above

22a SIGNATURE: Ralph Lyons Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/23/61
22c PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JULY 25, 1961
23c. NAME OF CEMETERY OR CREMATORY: EBENEZER CEMETERY
23d LOCATION (City, town, or county) (State): ROMNEY, W.VA.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Margaret R. Rowland, CLEAR SPRING, MD.
25a. REC'D BY REGISTRAR DATE: JUL 26 '61
25b REGISTRAR'S SIGNATURE: Arline L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8548

CERTIFICATE OF DEATH

Reg. Dist. No. 08543

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Pa. TX → b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle - Rural
d. STREET ADDRESS RD1 - Greencastle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CYRUS Middle LESLIE Last SITES

4. DATE OF DEATH Month July Day 14 Year 19 61

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 5/10/1880

9. AGE (In years last birthday) 81 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer (Retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Upton, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Cyrus Sites

14. MOTHER'S MAIDEN NAME Amelia Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 187-16-5537

17. INFORMANT Cora Sites Address RD1 Greencastle Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial dilitation — INTERVAL BETWEEN ONSET AND DEATH 6 wks.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary sclerosis-thrombosis-myocardial infarction — 6 wks.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Benign prostatic hypertrophy. Uremia, due to renal sclerosis.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept., 1959, to July 14, 1961, that I last saw the deceased alive on July 14, 1962, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W.C. Brewer M.D. ADDRESS (Street, city or town, state) 359 East Baltimore St., Greencastle, Penna. DATE SIGNED

PHYSICIAN'S NAME (Type) W.C.Brewer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) B. 22b. DATE THEREOF 7/17/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. 22d. LOCATION (City, town, or county) (State) Greencastle Pa.

23. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnich ADDRESS Greencastle Pa.

24a. REC'D BY REGISTRAR DATE JUL 19 61

24b. REGISTRAR'S SIGNATURE Arthur S. Kyner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8550 — 08544

(M) DR. SHEALY X

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 11 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 206 POTOMAC ST.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: 206 POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRTLE Middle E. Last SMITH

4. DATE OF DEATH: Month JULY Day 14 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 17 1892
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months 10 Days 27 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): MT. TABOR FRED. CO. MD ~~WASH. CO. MD~~
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: EZRA HOUPT
14. MOTHER'S MAIDEN NAME: LILLY DOAT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS GLENN E. MANN
Address: BOONSBORO MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): Metastatic carcinoma of the hip & spine — INTERVAL BETWEEN ONSET AND DEATH: 7 MONTHS

174 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of the uterus — 16 MONTHS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/11/61, 19..., to 7/14/61, 19..., that (I) (we) last saw the deceased alive on 7/14/61 19..., and that death occured at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Walter H Shealy M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/15/61
22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.
22d. ADDRESS: SHARPSBURG WASH. CO. MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: July 17 1961
23c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEMETERY
23d. LOCATION (City, town or county) (State): LOCUST GROVE WASH. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John N. Bast
ADDRESS: BOONSBORO MD
25a. REC'D BY REGISTRAR DATE: JUL 19 '61
25b. REGISTRAR'S SIGNATURE: Catherine L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8551 · 38545

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 25 Mt. Airy Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Arthur — Last: Snider

4. DATE OF DEATH: Month: July — Day: 25 — Year: 1961

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 16, 1894 — 9. AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Production Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: machine tool ind.

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles D. Snider

14. MOTHER'S MAIDEN NAME: Mamie Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 173 03 1136

17. INFORMANT: Mrs. Robert B. Rowe — Address: Waynesboro, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO (b): Coronary Atherosclerosis
DUE TO (c): (Previous Coronary 8 Wks ago)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 Hours / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 May 1961, to 23 July 1961, that (I) (~~not~~) last saw the deceased alive on 23 July 1961, and that death occurred at 4:30 AM, from the causes and on the date stated above

22a. SIGNATURE: J. D. Wilson — M.D

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/25/61

22c. PHYSICIAN'S NAME (Type): J. D. WILSON, M.D.

22d. ADDRESS: 135 N. POTOMAC ST. HAGERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/28/61

23c. NAME OF CEMETERY OR CREMATORY: Green Hill

23d. LOCATION (City, town, or county) (State): Waynesboro, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: Talley Y Gore — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR — DATE: JUL 27 '61

25b. REGISTRAR'S SIGNATURE: Clarence S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6552 08546

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pinesburg
c. LENGTH OF STAY IN 1b: MARYLAND Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport RFD # 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Pinesburg
d. STREET ADDRESS: Williamsport RFD # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna Middle: Dean Last: Staley
4. DATE OF DEATH: Month: July Day: 14 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 8, 1876
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months: 4 Days: 6 IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Pinesburg, Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: William Banzhoff
14. MOTHER'S MAIDEN NAME: Mary Ann Null
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John Banzhoff Address: Williamsport, Md. RFD #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 — Acute myocardial infarction — Interval between onset and death: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.):
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/14/61, 19..., to 7/14/61, 19....., that (I) (we) last saw the deceased alive on 7/14/61, 19....., and that death occured at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph Strong
22b. DATE SIGNED: 7/15/61
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 16, 1961
23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery
23d. LOCATION (City, town or county) (State): Near Clearspring, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf ADDRESS: Williamsport, Md.
25a. REC'D BY REGISTRAR DATE: JUL 18 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

93547

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 30 Summit Ave.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 05 Hagerstown
d. STREET ADDRESS: 669 Highlandway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Norman — Middle: Michael — Last: Stauffer

4. DATE OF DEATH: Month: July — Day: 17 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 23, 1924

9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (State or foreign country): Lainbridge, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter W. Stauffer

14. MOTHER'S MAIDEN NAME: Ellen L. Reno

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W. W. II

16. SOCIAL SECURITY NO.: 549-26-7570

17. INFORMANT: Address: Mrs. Geraldine C. Stauffer Ha[illegible] Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mitral Stenosis
420.1
DUE TO: Cardiac Hypertrophy & Dilatation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Mural Thrombus, Left Atrium
DUE TO: Pulmonary Congestion
(c) Coronary Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH: Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: July 13, 1961

EXAMINER'S NAME (Type): Dr. F. W. Ditto, Jr.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-21-61
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or country) (State): Lancaster, Pa.

23. FUNERAL DIRECTOR — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 20 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8554 Lucy 9 Fitch Dietl 99543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
   c. LENGTH OF STAY IN 1b: 5yrs-1month
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Pennsylavania
   b. COUNTY: ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shippensburg, Pennsylavania
   d. STREET ADDRESS: 400 W. King Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF (Type or print): First Guy — Middle — Last STAVER

4. DATE OF DEATH: Month July — Day 17 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 18, 1881

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Pharmacist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Newburg, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alonza STAVER

14. MOTHER'S MAIDEN NAME: Bertha BOHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Guy STAVER — Address: 400 W. King St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion (acute) — Interval between onset and death: 6 hrs
DUE TO (b): Generalized Atherosclerosis — 6 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pyoderma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 1958 to 7-18-61, that (I) (we) last saw the deceased alive on 7-15 1961, and that death occured at 4:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M.E. Byrkit — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7-18-61

22c. PHYSICIAN'S NAME (Type): M.E. Byrkit

22d. ADDRESS: Williamsport, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Jul 19-61 — 23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery — 23d. LOCATION (City, town or county) (State): Shippensburg-Cumberland, Pa

24. FUNERAL DIRECTOR'S SIGNATURE: Allen C. Hess — ADDRESS: Shippensburg, Pa

25a. REC'D BY REGISTRAR: DATE JUL 19 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8555

CERTIFICATE OF DEATH

08549

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 34 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 516 Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Augustus; Middle: ; Last: Stump

4. DATE OF DEATH: Month: July; Day: 14; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 13, 1919

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contruction Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Construction Co.

11. BIRTHPLACE (County & State, or foreign country): Flint, Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles W. Stump

14. MOTHER'S MAIDEN NAME: Rose Spicer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 213-12-7186

17. INFORMANT: Mrs. Frances Stump
Address: Hagerstown, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	generalized carcinomatosis	unknown
DUE TO (b)	carcinoma of sigmoid colon	16 months
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 14, 1961, that (I) (we) last saw the deceased alive on July 14, 1961, and that death occured at 10:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: July 14, 1961

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: Western Md. State Hospital, Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/18/1961

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: R. Franklin Zeiger
Suter - Houzer Funeral Home
ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR
DATE: JUL 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8555 — 28550

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: most of life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 128 Calvert Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOSEPH	BURTON	TOWNSHEND	July	1	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white		February 18, 1896	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
District manager	insurance company	Westminister, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jeremiah Belt Townshend	Hanna Mary Ecker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes W.W. I & II	219-28-5984	Mrs. Philippa Townshend	Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis

DUE TO (b) Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work ☐ Not White at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1, 1961 to July 1, 1961, that (I) (we) last saw the deceased alive on July 1, 1961, and that death occured at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. S. Stauffer — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 3, 1961

22c. PHYSICIAN'S NAME (Type): R.S. STAUFFER

22d. ADDRESS: Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	7/6/1961	Arlington National Cemetery	Arlington	Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Bouzer Funeral Home — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE JUL 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3557

CERTIFICATE OF DEATH

09551

1. **PLACE OF DEATH**
   a. COUNTY: Washington — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
   c. LENGTH OF STAY IN 1b: 10 wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gateway Convalescent Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Smithsburg R # 2
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nettie — Middle: Virginia — Last: Varner

4. DATE OF DEATH: Month: July — Day: 17 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 8, 1878

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State or foreign country): Washington County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Kershner

14. MOTHER'S MAIDEN NAME: Annie M. Stotler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Edgar W. Varner — Address: R # 2 Smithsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 — 20d. INJURY OCCURRED: While at work [ ] Not While at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (th's hospital) attended the deceased from May 16, 19 61 to July 17, 19 61 that (I) (we) last saw the deceased alive on July 17, 19 61, and that death occured at 7:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: David R. Brewer M.D.
ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7/18/61
22c. PHYSICIAN'S NAME (Type): David R. Brewer
22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 20, 1961
23c. NAME OF CEMETERY OR CREMATORY: Beautiful View Cemetery
23d. LOCATION (City, town or county): Middleburg (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm. A. Hoop
ADDRESS: Rest Haven Funeral Home Hagerstown, Md.

25a. REC'D BY REGISTRAR: DATE JUL 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8553 08552

1

TO HOLD FOR BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: Life time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d. STREET ADDRESS: 146 N. Jonathan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bailey — Middle: — Last: Walker

4. DATE OF DEATH: Month: July — Day: 2 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 2 1900

9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laberer

10b. KIND OF BUSINESS OR INDUSTRY: Building const.

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Bailey Walker Sr.

14. MOTHER'S MAIDEN NAME: Mary French

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-09-9924

17. INFORMANT: Christine Lyles, Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrene of Rt. lung — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Rt. lung — 13 months
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

(1) Lobular pneumonia, left lung (2) Old posterior wall infarction (3) Hydronephrosis, left kidney

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 29 1960 to July 2 1961 that (I) (we) last saw the deceased alive on July 2 1961 and that death occurred at 5:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: July 2, 1961

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: Western Md. State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-7-1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John R Watson Jr Hagerstown Md

25a. REC'D BY REGISTRAR DATE: JUL 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8559

CERTIFICATE OF DEATH

08553

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 132 Greenberry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Terry Middle: Wetzel Last: Walker

4. DATE OF DEATH: Month: 7 Day: 10 Year: 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7 - 7 - 61

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months: Days: 3 — IF UNDER 24 HRS: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wetzel B. Walker

14. MOTHER'S MAIDEN NAME: Glenna Mae Bragg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Wetzel B. Walker Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Frank Breech

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7 19 61 to 7/10 19 61 that (I) (we) last saw the deceased alive on 7/10 19 61, and that death occurred at 11A M. from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D

ATTENDING PHYS X MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-10-61

22c. PHYSICIAN'S NAME (Type): Paul Harrison, M. D.

22d. ADDRESS: 313 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 7-13-61

23c. NAME OF CEMETERY OR CREMATORY: End of the Trail

23d. LOCATION (City, town, or county) (State): Sam Blacks W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Kraiss Funeral Home ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G-42 8/9/61 jwk

CERTIFICATE OF DEATH

8559 Reg. Dist. No. 08554

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: HENRY; Middle: ; Last: WARREN

4. DATE OF DEATH: Month: July; Day: 29; Year: 1961

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: unknown

8. DATE OF BIRTH:

9. AGE (In years last birthday): 74? yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): RICHMOND, VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEDICAL RECORD — WASH. CO. HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from July 27, 1961 to July 29, 1961 that I last saw the deceased alive on July 28, 1961, and that death occurred at 3:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D.
ADDRESS (Street, city or town, state): 318 N. Potomac St., Hagerstown, Md.
DATE SIGNED: 8/1/61

PHYSICIAN'S NAME (Type): PAUL HARRISON

22a. BURIAL—CREMATION, REMOVAL (Specify):
22b. DATE THEREOF: 8.1.'61
22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Minnich Funeral Home, Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 3 '61

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death: Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

856 1 — 08555

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 13 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 7207 Rhode Island Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NANCY — Middle MELINDA — Last WELLS

4. DATE OF DEATH: Month July — Day 9 — Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 14, 1943

9. AGE (In years last birthday): 17 yrs. — IF UNDER 1 YEAR, Months, Days — IF UNDER 24 HRS., Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David E. Wells

14. MOTHER'S MAIDEN NAME: Elinore Hightman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. David E. Wells College Park, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LACERATON OF LIVER WITH IRRIVERSIBLE — INTERVAL BETWEEN ONSET AND DEATH

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): SHOCK DUE TO BLOOD LOSS. — 13 HRS.

DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): GOING WRONG WAY ON ONE WAY ST. STRUCK ONCOMING CAR.

20c. TIME OF INJURY Hour, Month, Day, Year: 11:40PM 7-8-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): XS. MULBERRY ST.

20f. (City or town) (County) (State): HAGERSTOWN WASH, MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DR. E.W.DITTO, JR.

Address (Street, city, town, or county):

DATE SIGNED: 7/12/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 12, 1961

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: JUL 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8562

CERTIFICATE OF DEATH

08556

1

M

I

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 Yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 16555 Emory Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15 12-2

3. NAME OF DECEASED (Type or print): LAWRENCE (First) A (Middle) WHITTAKER (Last)
Lawrence A. Whittaker

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: May 25 1901

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (County & State, or foreign country): Rhode Island Pawtucket Providence Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 577-07-6197

17. INFORMANT: Mrs Marilyn W. Johns — Address: 16555 Emory Lane Rockville Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Purpura Hemorrhagica — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Aplastic Anemia — 1 MONTH
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

292.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): (1) Rheumatoid arthritis (2) Psoriasis (3) Auricular Fibrillation

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 4, 1961 to July 6, 1961, that (I) (~~we~~) last saw the deceased alive on July 6, 1961, and that death occured at 4:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: July 6, 1961

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: Western Maryland State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/8/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: JUL 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8563 **CERTIFICATE OF DEATH** 08557

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1917 Gay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Franklin — Last: Williar

4. DATE OF DEATH: Month: July — Day: 26 — Year: 1961

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Aug. 22, 1890 — 9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Section Forman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & State, or foreign country): Near Thurmont, Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Harry I. Williar
14. MOTHER'S MAIDEN NAME: Margaret C. Eby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): W. W. 1
16. SOCIAL SECURITY NO.: 705-10-5954
17. INFORMANT: Fred Williar — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arterio Sclerosis Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-20-61, 19..., to 7-26-61, 19..., that (I) (we) last saw the deceased alive on 7-25-61, 19..., and that death occured 4:15 M, from the causes and on the date stated above.

22a. SIGNATURE: K. E. Dutto M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): K E Dutto Jr — 22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 7-29-61 — 23c. NAME OF CEMETERY OR CREMATORY: U. B. Cemetery — 23d. LOCATION (City, town or county) (State): Thurmont, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott. F. Minnich & Son Hagerstown, md — 25a. REC'D BY REGISTRAR DATE JUL 31 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60